AMC HEALTH CARE TASK FORCE
Report and Recommendations

July 7, 2008

Purpose

The AMC Health Care Task Force was formed in fall of 2007 in anticipation both of a) legislative proposals coming forward in 2008 and b) a need to look at long-term solutions to health care issues affecting counties. While AMC has a number of positions related to local government public health functions, publicly funded health care programs, and health insurance for county employees, the AMC board recognized that AMC lacked a comprehensive policy and strategy to guide legislative advocacy for counties roles in health reform. The growing urgency of health issues in Minnesota's communities and the health reform debate at the legislature demanded that counties become well informed about these discussions and develop a broader, deeper, and more consistent set of positions on health care in order to influence policy discussions.

The AMC Board charged the Health Care Task Force to develop a comprehensive legislative position and strategy on health reform efforts affecting county government.

Membership, Staffing, and Timeline

The group consisted of the following members and other resource people:

- Fifteen county commissioners representing geographic areas throughout the state;
- Four representatives from each of the following departments: county administrators or coordinators; public health directors, and human services directors. (These individuals were identified as subject matter experts rather than voting members but asked to attend all meetings and participate in the discussions).
- Other individuals, such as legislators, state agency staff, and other resource people were invited as needed to inform the discussion.
- The group was staffed by the AMC Health and Human Services Policy Analyst. Other staff, such as LPHA and MACSSA directors and AMC management team, were invited and participated occasionally.

A list of task force members is included in Appendix A.

The following external resource people provided insights and expertise to this discussion and the discussion of AMC positions. They included:

- Former Senator David Durenburger, who now leads the National Institute of Health Policy, spoke on Health Care Challenges and Changes;
- Julie Sonier, Director of the Health Economics Program at the MDH, presented information on trends in health insurance costs and coverage;
- Elizabeth Lukanen, of the University of Minnesota Health Access Data Assistance Center, presented information on models from other states;
- Susan Castalano and Dr. Jeff Schiff, DHS, and staff of the MDH Children with Special Health Needs shared information on health care home pilots;
- Cara McNulty, Minnesota Department of Health, provided an overview of the Statewide Health Improvement Plan and the Steps Model.
- Senator Linda Berglin, Chair of the Senate Health and Human Services Finance Committee, Scott Leitz, Assistant Commissioner for MDH, and Cara McNulty presented on the health reform legislative proposals at the AMC Legislative Conference.

Timeline

The group met four times from November 2007--February 2008. In addition, the Task Force convened by conference call once and also communicated several times via e-mail during the session. Updates were provided at AMC board meetings and to all AMC members through the AMC Update, web site, and legislative conference. The Task Force met on June 30, 2008 to review the legislation passed and discuss next steps.

Need for Health Reform:

Counties have expressed concerns that the current health system is unsustainable and that lack of reform will significantly impact the business of county government. Structured conversations were held at both the 2007 AMC Policy Committee and the fall district meetings to gather input from members. Among the specific concerns expressed:

- Rising employee health insurance costs are affecting all aspects of county government and draining resources from service delivery;
- Access to some providers (mental health, dentistry) is limited, especially in rural areas;
- Focus on acute disease is expensive and inhibits efforts to prevent health problems from occurring;
- Lack of primary care providers and higher reimbursement for specialty care results in fragmented care;
- Eligibility and enrollment for public programs (e.g., Medicaid and MinnesotaCare) is far too complex and results in long waiting lists and expensive administration;
- Rising numbers of uninsured or underinsured place additional pressures on county human services budgets and on public hospitals;
- Lack of integration between social services and health care limits the ability to maintain health for vulnerable people;
- Minnesota is one of the healthiest states in the nation, but we experience disparities in health outcomes among people of color;

- Our health outcomes lag behind those of developing countries even though we spend more per capita for health care;
- Many Minnesota communities have aging populations and these individuals are at greater risk for chronic disease and associated costs;
- Many small employers (including some counties) have dropped or are considering discontinuing employee coverage due to increased premiums;
- Risk factors such as childhood obesity, tobacco use, and alcohol abuse are increasing, thus increasing health care costs.

Counties' Perspective on Health Reform

The Task Force discussed and agreed to recommend to the AMC Board an overall framework for health reform as it affects county government. They also identified roles for counties in health reform and principles to inform AMC positions on health reform proposals that would be considered by the legislature in 2008.

Toni Smith, University of Minnesota Extension Services Liaison to AMC, facilitated an extensive discussion of a framework, county roles, and principles at the December meeting.

In the initial conversations, there was considerable debate as to whether health care was a right of all citizens or a free enterprise product, and whether a comprehensive solution required embracing one approach over the other. The group did not reach consensus on this issue and decided they could better focus their discussions on issues where there was common agreement. Initial discussion also centered on whether to embrace the legislative goal of universal health care. While there was support for all Minnesotans having the opportunity to enjoy good health, some Task Force members believed that the term "universal health care" implied a single payer model of health care, which not all members supported. The group reached consensus on a framework for health reform that they not only agreed to but that they felt could get buy-in from the majority of county boards. This framework emphasized public health activities as a way to prevent disease and reduce health problems and associated costs as well as emphasizing value in quality of care and return on investment.

The Task Force then affirmed the variety of roles that counties have in the health system. Identifying these roles was seen as important because it illustrated the extent of counties interest and responsibility in the health system. It also helped provide several "lens" through which to view various legislative proposals rather than taking a position based on one perspective (e.g., employer or social services safety net) without considering other county responsibilities. Finally, the Task Force reviewed and adapted a list of principles, developed by a previous work group, to guide review of legislative proposals. The Framework, Roles, and Principles are included below.

AMC HEALTH CARE TASK FORCE

FRAMEWORK FOR ADDRESSING HEALTH REFORM

All Minnesotans should have the opportunity to be healthy.
To reach this goal, AMC supports public health activities that prevent disease and disability and promote health for the whole population.

AMC supports health care for all Minnesotans that adds value by 1) improving quality and patient satisfaction; 2) decreasing medical errors, cost, and waste; and 3)maximizing return on investment.

County Roles in the Health System

Counties have many roles in the health care system and thus are directly affected by changes in health care policy and financing being considered in the legislature. Among these roles are:

- Safety net for uncompensated care (especially those with county-owned hospitals)
- Health plan for public programs*
- Contractor for health-related social services
- Gatekeeper for eligibility for publicly funded health care programs
- Conductor of outreach/case management to get eligible people enrolled in publicly funded health care programs
- Local board of health with statutory responsibility for protecting, maintaining, and improving the health of the entire county's population
- Purchaser of health care for county employees

* 27 counties currently participate in county-based purchasing; additionally, one county entity (Metropolitan Health Plan in Hennepin County) is licensed as a commercial health plan

PRINCIPLES TO USE WHEN ANALYZING HEALTH REFORM PROPOSALS FROM A COUNTY PERSPECTIVE

To what extent does the proposal:

1. Strengthen the public health system;
2. Promote prevention, early diagnosis and incentives to encourage personal responsibility for healthy living;
3. Recognize the value of community supports that enable people to lead healthy and stable lives in spite of medical conditions that impact physical and mental health;
4. Make it possible for all Minnesotans to have health care coverage;
5. Reduce health disparities and enable local flexibility in service delivery;
6. Reinstate benefits within Medical Assistance, MinnesotaCare and General Assistance Medical Care [to previous funding levels];
7. Increase support for entities that provide safety net functions such as counties, community clinics, safety net hospitals, and mental health providers;
8. Reduce opportunities to shift the cost and responsibility for the provision of needed services to county taxpayers instead of actually reducing costs.
9. Simplify the administrative process;
10. Improve health and increase value of investment of health care dollars; and
11. Allow consumer choice of provider of health care.

Adopted January 2008; AMC Health Care Task Force

Counties' Contribution to Health Reform Legislation

The 2007 legislature authorized two task forces charged to develop legislative proposals to reduce health care costs and achieve universal access. These were: the governor's Transformation Task Force, chaired by DHS Commissioner Cal Ludeman and Representative Tom Huntley; and the Health Care Access Commission, chaired by Senator Berglin and Representative Huntley. Counties participated in several of the working groups for the Health Care Access Commission which met over the summer and fall. Recommendations from these two groups and [in later meetings], legislative proposals arising from the groups, were discussed at each AMC Task Force meeting. Among the proposals the Task Force reviewed was:

- **Statewide Health Improvement Plan (SHIP):** Establish and fund a statewide health improvement program to reduce the percentage of Minnesotans who are obese or overweight and reduce use of tobacco. Funding would be channeled through community health boards (county, multicounty and city health departments) to local community organizations. This proposal arose out of a recommendation from a work group of the State Community Health Services Advisory Committee at MDH;

- **Health Care Coverage and Affordability:** Various proposals, including expanding MinnesotaCare; reducing MinnesotaCare premiums; streamlining access to applications for state public health care programs; section 125 plans to use pre-tax dollars to purchase insurance coverage; tax credits for purchasing health care; design of an 'essential benefit set' to provide a basic level of benefits; creation of an affordability scale with subsidies for those outside that scale;

- **Care Coordination/Chronic Disease Management:** Establish health care homes to coordinate care for people with certain chronic diseases. Increased payment would be available for clinics certified as health care homes;

- **Payment Reform and Quality/Price Transparency**: Provide information to allow consumers to compare price and quality; allows providers to bid on 'baskets' of health care services to allow better comparisons; strategies for consumer engagement;

- **Administrative Efficiency**: Interoperable medical records requirement;

- **Other**: Workforce studies, incentives for primary care providers to practice in rural areas; health care coverage for long-term care workers; more use of midlevel practitioners; use of health plan community benefit funds for funding source; estimated 12-20% cost-savings to be channeled back into health care system.

Upon hearing and discussing information on these proposals, the committee voiced support for:

- Establishing and funding SHIP to community health boards;

- The concept of health care homes, while encouraging the legislature to consider how counties may be involved with health care homes in coordinating care for vulnerable people on public programs;
- Other models to better coordinate health and social services, such as county-based purchasing;
- Expanding MinnesotaCare, while urging the legislature streamline eligibility and enrollment;
- Efforts to increase affordability of health care by reducing premiums as well as subsidizing coverage;
- Transparency in price and payment, especially in use of public dollars.

The Task Force shared these recommendations with the AMC Health and Human Services Policy Committee, the AMC Board, and, at the Spring Legislative Conference, with the general membership. These groups affirmed AMC support for some specific components of the bill. Staff used this input in lobbying and testifying before the legislature on health reform proposals, proposing language changes to the bill, and in voicing AMC's official support for various aspects of the health reform proposals. AMC and LPHA were most involved in providing input on the Statewide Health Improvement Plan, in the discussion of county based purchasing as a viable model for integrated health and social services in health care.

The committee also discussed how health care costs affect county operations, such as rising employee health care costs and the impact on the overall county budget. This discussion included both consideration of how the payment reforms and other legislative proposals might help but also discussion of what was and could be done at the local level to contain costs. The Task Force agreed that cost containment measures would certainly help their bottom line but did not think they had enough expertise to assess whether the proposals would be effective.

What Passed, What Didn't Pass

The proposals arising out of the Governor's Task Force and the Health Care Access Commission were met with mixed response from the Legislature. On one hand, there was strong recognition of the urgency of moving toward affordability and cost containment. However, legislators (and the governor) disagreed on whether the solution was a greater role for government or a more market-driven approach. Republican legislators and the governor did not support expanding health care coverage before significant reform and cost containment was achieved. Some Republicans proposals advocated market-based approaches, such as allowing for-profit health plans [to increase competition] and reducing malpractice claims. Later in the session, the governor expressed interest in including tax credits and health savings accounts. There was also limited support among both Republicans and Democrats for financing the reforms through health plan assessments. Some Democrats felt a mixed market and public sector approach would not succeed and advocated stronger movement toward single payer system. Finally, there was bipartisan support for payment reform and health care homes. However, there was concern that the models proposed were too metro centric and placed too much responsibility on providers for outcomes. In the end the health care home and payment model was included but in a more limited form than previously proposed.

In the last days of the session, the legislature passed a bill that was vetoed by the governor. The legislature, on the last night of the session passed a new bill that was subsequently signed by the governor. Some of the features discussed by the AMC Task Force are included in this bill: the statewide health improvement plan, care coordination, minimal expansion of MinnesotaCare. Other components are addressed through study groups or reports, such as an essential benefit set and affordability. An MDH summary of the health reforms is included in Appendix B.

What's Next for Health Reform?

MDH and DHS are charged with implementing the health reform law. Some parts of the law have implications for counties. Counties should be involved in discussions as implementation moves forward. Task Force members can add value to health reform implementation by:
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- Identifying key areas of interest/responsibility for counties;
- Framing questions/issues that, from a county perspective, should be addressed in moving forward with each proposal;
- Describing potential implications for work done by counties or populations currently served by counties who may be impacted by the new law;
- Identifying opportunities to engage in dialog with state agencies and others as implementation begins.

The Task Force, at its June meeting, reviewed the legislation that passed and identified several key areas of high county interest and responsibility. These are:

- Language authorizing *health care homes and payment reform* for 'baskets of care' for people who have or are at risk of developing chronic disease. The Task Force suggested this reform has implications for social services or public health case management activities. Counties currently perform such activities for many vulnerable people, especially those on publicly funded health care programs. Members expressed strong interest in being engaged in future discussions on this topic.
- *Statewide Health Improvement Plan*, by which community health boards (primarily county entities) would receive grant funding in June 2009 to reduce risk factors in order prevent chronic disease and associated health care costs. While fully supportive of this initiative, members expressed reservation about the financing mechanism and the 10% local match requirement.
- *Expansion of MinnesotaCare*, while modest, has implications for the counties that administer this program. Counties continue to be concerned about administrative complexity of Minnesota's publicly funded health care programs.
- Other aspects of payment reform, price transparency, and affordability may also impact counties; however, it is too soon to say how and to what extent.

Who should be involved in these discussions? The Task Force believes they can add value by serving as a 'sounding board' for a broad county discussion of these issues. More focused discussions may be continued by other groups, such as AMC affiliates or a subgroup of the Task Force. The Task Force recommended that it be convened at the

call of the chair to advise AMC as implementation begins. Also, Task Force members will be surveyed to get their input on specific questions/issues regarding health reform implementation.

Beyond Health Reform Legislation: Counties and the Local Health System

The legislation passed in 2008, while significant, represents beginning steps toward health reform. The new law will likely stimulate efforts in communities to improve quality and access and reduce costs. As usual, the local community is "where the rubber meets the road". Counties have important roles in the local health system and are uniquely positioned to provide leadership in improving the health of their employees, their clients, and their communities.

Questions to consider include:

- What are some efforts in which counties can engage with their communities to improve health?
- What are the implications for counties taking a greater leadership role in improving health?
- What resources are needed to make this happen? Will budget constraints, levy limits, etc. pose an insurmountable barrier?
- Does AMC or the Health Care Task Force have a role in stimulating these discussions? If so, what is it?

There was limited time to discuss these questions at the June 30 meeting of the Task Force. More follow-up is needed with the task force and other county representatives to ascertain if this is a role that this task force, or perhaps another group sponsored by AMC, should take on.

Appendices

Appendix A
Task Force Members and Resource Persons

Members:

Commissioner John Baerg, Watonwan County
Commissioner Ben Brunsvold, Clay County
Commissioner Doc Carlson, Hubbard County
Commissioner Toni Carter, Ramsey County
Commissioner Thomas Clifford, Lake County
Commissioner Kathleen A. Gaylord, Dakota County
Commissioner Norman Holmen, Cottonwood County
Commissioner Larry Kittelson, Pope County (Chair)
Commissioner Susan Morris, Isanti County
Commissioner Steve O'Neil, St. Louis County
Commissioner James Peterson, Waseca County
Commissioner Ted Seifert, Goodhue County
Commissioner Rhonda Sivarajah, Anoka County
Commissioner Bill Stearns, Wadena County
Commissioner Beverly Wangerin, McLeod County
Commissioner Amy Wilde, Meeker County
Commissioner Paul Wilson, Olmsted County

Resource Persons:

Riaz Aziz, Coordinator, Pope County
Jennifer Deschaine, Community Health Services Administrator, Scott County
Paul Fleissner, Community Services Director, Olmsted County
Tom Henderson, Social Services Director, Brown County
Kate Lerner, Director and Legislative Liaison, MACSSA
Jane Norbin, Health Policy, Ramsey County
Alan B. Peterson, Coordinator, Kanabec County
Julie Ring, Director, LPHA
Melvin J. Ruppert, Administrator, Nobles County
Jim Schug, Administrator, Washington County
Jerry Soma, Human Services Division Manager, Anoka County
Mary Wellik, Public Health Director, Olmsted County
Sue Zuidema, Human Services & Public Health Dept (HSPHD) Area Director, Hennepin County

Staff:

Patricia Coldwell, Policy Analyst, AMC

Appendix B

MDH 2008 Health Care Reform Summary (see following pages)
http://www.health.state.mn.us/divs/opa/08reformsummary.pdf

Other References:

Health Care Transformation Task Force Final Report 2008
http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf

Health Care Access Commission Final Report 2008
http://www.commissions.leg.state.mn.us/lchca/HCAC%20Report%20final%202-08.pdf

June 2008

2008 Health Care Reform Summary

In 2008, Governor Pawlenty signed significant health care reform legislation into law. These reforms, which include recommendations of the Governor's Transformation Task Force and the Legislature's Health Care Access Commission**,** create a comprehensive health care package making significant advances for Minnesotans in the following areas:

Public health

- Establishes and funds a statewide health improvement program to reduce the percentage of Minnesotans who are obese or overweight and reduce the use of tobacco.
- Appropriates a total of $47 million for this activity in fiscal years 2010 and 2011.

Health care coverage/affordability

- Provides MinnesotaCare coverage for an estimated 8,700 additional people by 2011.
- Expands MinnesotaCare eligibility for adults without children to 250 percent of federal poverty and parents with incomes up to $57,500 annually.
- Reduces the MinnesotaCare sliding-fee premiums to increase affordability.
- Increases outreach for state health care programs.
- Streamlines access to applications for state public health care programs and requires further study to improve coordination between state health care programs and other assistance programs.
- Requires the study and development of a proposal to promote affordable access to employer-sponsored health insurance through the use of direct subsidies and/or tax credits and deductions.
- Requires employers that have 11 or more full-time equivalent employees and do not offer group health insurance to establish and maintain a Section 125 Plan, which allows employees to purchase health insurance with pre-tax dollars. Employers have the opportunity to opt out of this requirement.
- Provides grants and tax credits to cover certain employers' cost of establishing Section 125 Plans.[1]
- Agreement to establish a tax credit for the uninsured to purchase coverage through a Section 125 Plan.
- Creates a workgroup to make recommendations on the design of an "essential benefit set" that provides coverage for a broad range of services and technologies, is based on scientific evidence of clinical and cost effectiveness, and requires lower enrollee cost-sharing for certain services.

Chronic care management

- Promotes the use of "health care homes" to coordinate care for people with complex or chronic conditions.
- Requires DHS and MDH to develop and implement standards of certification for health care homes by July 1, 2009.
- Establishes standards for state certification of health care homes and evaluating outcomes. Health care homes will receive care coordination payments from public and private health care purchasers.

Payment reform and price/quality transparency

- Encourages quality improvement, by increasing transparency of quality and establishing a single statewide system of quality-based incentive payments to be used by public and private health care purchasers.

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- Creates a powerful set of tools to allow consumers and health care purchasers to compare providers on overall cost and quality of care. This information will be used to create incentives for health care providers to innovate on ways to deliver health care with higher quality and lower cost and it will also be used to create consumer incentives to use high-quality, low-cost providers.
- Promotes transparency and accountability by establishing "baskets" of health care services to allow consumers to more easily compare cost and quality of care across providers, and to promote provider innovation on cost and quality.
- Convenes a workgroup to develop strategies for engaging consumers in understanding the importance of health care cost and quality, specifically as it relates to health care outcomes, consumer out-of-pocket costs, and variations in cost and quality across providers.
- Provides for legislative oversight and establishes a Health Care Reform Review Council for stakeholder review and input on implementation of the payment reform provisions of the bill.

Administrative efficiency

- Enhances heath care quality, patient safety and Minnesota's ability to achieve interoperable electronic health records by ensuring that providers use nationally-certified electronic health record systems when available.
- Advances the use of health information technology by requiring that all prescriptions be ordered electronically by 2011.
- Requires a study and report on reducing claims adjudication costs for health care providers and health plans by adopting more uniform methods of processing claims.

Health care cost containment

- Requires health care cost savings to be measured against projected costs without reform.[2]
- Results in significant potential overall health care cost savings. Compared to baseline projections, the health care reforms in this bill are estimated to have the potential for cost savings of about 12 percent by 2015. This represents a potential savings of about $6.9 billion compared to baseline projections.

Other

- Requires a study and report on health care workforce shortages.
- Requires a study and report on community benefit standards for nonprofit health plans.
- Requires a study and report on health care coverage for long-term care workers.
- Requires a workgroup to develop recommendations for the education and regulation of oral health practitioners.[3]

Endnotes

The health reform measures passed this session are included in the health care reform bill, Chapter 358, Senate File 3780, unless otherwise noted.

1. Omnibus tax bill
   Chapter 366, House File 3149
2. Supplemental budget bill
   Chapter 363, House File 1812
3. Omnibus higher education bill
   Chapter 298, Senate File 2942